



Form CCRF Cigarette Complaint Referral Form

Massachusetts
Department of
Revenue

Complainant name (optional)

Complainant telephone number (optional)

Name of cigarette business

Owner/manager

Cigarette business telephone number

Business address

City/town

State

Zip

Issue/concern. Be as specific as possible. Include date and, if known, names of individuals involved.

Mail to: **Massachusetts Department of Revenue, Filing Enforcement Unit, Bureau of Desk Audit, 200 Arlington Street, Fourth floor, Chelsea, MA 02150**, or fax to: **(617) 887-6589**. Attach additional sheet if necessary.